APPEAL NO. 93021

This appeal arises under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8308-1.01 *et seq*. (Vernon Supp. 1993) (1989 Act). On December 4, 1992, a contested case hearing (CCH) was held in (city), Texas, with (hearing offier) presiding as hearing officer. The hearing officer determined that the appellant (claimant herein) reached maximum medical improvement (MMI) on September 28, 1992 with an impairment rating of 12 percent.

Claimant contends that the hearing officer misapplied the facts, that claimant has not reached MMI, that an impairment rating is premature, that the great weight of the other medical evidence is contrary to that of the designated doctor, and requests that we reverse the hearing officer's decision and render a decision in her favor. Respondent, carrier herein, responds that the decision is supported by the evidence and requests that we affirm the decision.

DECISION

The decision of the hearing officer is affirmed.

Claimant was a 22-year-old pharmacy technician employed by (employer). Claimant testified, and it is undisputed, that on (date of injury) she was injured at work when she dropped a box of IV fluid containers. Claimant alleges the box hit the top of her left foot and that she injured her left foot, knee and back. Claimant testified she was taken to the emergency room and x-rayed. Claimant testified that there were no broken bones, but she was issued crutches and placed on a two week therapy program. Claimant testified she was initially treated by (Dr. A). Claimant further testified that when her foot did not improve she saw (Dr. O).

Claimant testified that she first saw Dr. O in June 1991 with major complaints being her left foot and knee but that she did have pain in her lower back. Dr. O's Initial Medical Report, TWCC-61, dated 06-04-91, was regarding the foot injury and "released" claimant to stay off work. A Specific and Subsequent Medical Report, TWCC-64, dated 10-08-91, still dealt with the foot injury, released claimant to go to work and found no impairment. Reports of November 4 and 27, 1991 also dealt with claimant's foot injury. Dr. O filed TWCC-64s dated 01-06-92 and 05-08-92 dealing with the foot injury. Dr. O filed a TWCC-69, Report of Medical Evaluation, giving MMI of 04-16-92 with zero percent impairment. In the TWCC-69, Dr. O mentions "vague multiple symptoms."

Claimant apparently became dissatisfied with Dr. O and began treatment with (Dr. CH) who claimant first saw on May 6, 1992. Dr. CH submitted a number of reports, the first of which is dated 06-03-92, and lists ". . . complaints of pain in the left buttocks and left leg pain, dysesthesia and weakness . . . also complains of swelling in the left foot and ankle region." Apparently, some time in May 1992 Dr. CH completed a TWCC-69 which indicated MMI had not been reached with an estimate of MMI on "4-00-93." By report of 07-06-92,

Dr. CH notes "continued complaints of lumbar spine pain, thoracic spine pain and bilateral lower extremities pain." On 8-10-92 Dr. CH submitted a TWCC-64 with a diagnosis of "Thoracic STR/SPR, Lumbar STR/SPR and Unspec. Disorder--Auto Nervous System" and notes "Pt states she is working but missed approx. 1 week since July." By report dated 08-26-92 Dr. CH notes the thoracic spine region is essentially normal and "the lumbar spine myelogram shows a mild bulge at L5-S1 with CT post scanning." Dr. CH recommends "total conservative treatment and continuation of full work activity." By memo dated September 10, 1992, Dr. CH refers claimant to (Dr. CZ) "for treatment."

Dr. CZ submitted a multi-page narrative report dated June 29, 1992 in which he notes both the original left leg complaints and a low back pain. He recommends an MRI of the lumbar spine to rule out internal disc disruption. By report dated 11-2-92, Dr. CZ notes "[t]he patient has seen three Orthopedic Surgeons in the past." Dr. CZ further stated "[i]n my opinion, the patient has reached Maximal (sic) Medical Improvement and I do not expect her to get any better, anytime soon."

Other doctors who saw claimant on a referral basis were (Dr. MG) and (Dr. MC). Dr. MG, in a November 17, 1992 report, gave a clinical impression of "mechanical low back pain secondary to degenerative disk disease and disk protrusion at the L5-S1 level" in addition to mentioning the "status--post trauma to the left ankle . . ." Dr. MG concludes "I do not believe this patient is a surgical candidate . . ."

In November 1991, Dr. MC reported to Dr. O by report dated November 13, 1991, that an EMG examination was normal, noted a "sympathetic dysfunction," and suspects "an underlying anxiety of other pschological (sic) component."

The claimant introduces the results of an MRI study done by (Dr. B) on April 1, 1992 which showed "[a]t L5-S1 there is a mild degree of degenerative disc disease and a bulging of the annulus." Claimant also submits the results of a myelogram performed by (Dr. N) which was essentially normal with a notation "[t]here is a slight posterior protrusion of the lumbosacral intervertebral disc with flattening of the anterior surface of the thecal sac."

It was stipulated that (Dr. W) was a Commission appointed designated doctor, appointed by order of September 9, 1992, to determine MMI and percentage of impairment, if any. Dr. W submitted a TWCC-69, together with a two page narrative and computations on charts from the AMA Guides to the Evaluation of Permanent Impairment. Dr. W found MMI on 9-28-92 and assessed a 12 percent whole body impairment rating. Dr. W's narrative stated his impression was "1) [t]horacic sprain, improved; 2) lumbar radicular syndrome with left leg pain; 3) apparent contusion injury to left foot with possible causalgia minor." Dr. W feels claimant's prognosis is "good" because claimant is back working and then details how he arrived at a 12 percent impairment rating.

The hearing officer, in essence, accepted Dr. W's MMI date and impairment rating stating "[Dr. W]'s report dated September 28, 1992, is entitled to presumptive weight" and "[t]he great weight of other medical evidence is not contrary to [Dr. W]'s report." Claimant appeals stating she "is still injured and requires continued treatment . . . as she has not reached Maximum Medical Improvement by her doctor, any finding of physical impairment rating is inappropriate at this time." Claimant further contests Dr. W's assessment and, in effect, argues that Dr. W's report is contrary to the great weight of the other medical evidence.

Initially, we would point out that we have previously held that the fact that an employee may have reached MMI does not mean, in every case, that the individual is free of pain or has been fully restored to his or her preinjury condition. *See* Texas Workers' Compensation Commission Appeal No. 92270, decided August 6, 1992. We have also held that when a doctor finds MMI and assesses impairment he recognizes that the injured worker may reasonably continue to have effects, and quite possibly pain from the injury. Texas Workers' Compensation Commission Appeal No. 92670, decided February 1, 1993 and Texas Workers' Compensation Commission Appeal No. 92686, decided February 3, 1993. This appears to be exactly what Dr. CZ was saying in his report of 11-2-92 when he said MMI had been reached and he did not expect claimant to get better any time soon.

As discussed in Texas Workers' Compensation Commission Appeal No. 92412, decided September 28, 1992, in the not uncommon event of a disagreement between various medical reports and medical practitioners concerning reaching MMI and assessing an impairment rating, the legislature has provided a mechanism to resolve those disputes by the appointment of a designated doctor pursuant to Articles 8308-4.25 and 4.26 of the 1989 Act. Tex. W.C. Comm'n TEX. ADMIN. CODE § 133.2 (TWCC Rule 133.2) provides that medical reports and tests are to be provided to a designated doctor. Where the designated doctor is appointed by the Commission (instead of selected by mutual agreement of the parties) the report of the designated doctor "shall have presumptive weight" unless the great weight of the other medical evidence is to the contrary. In Appeal No. 92412, *supra*, we have noted the "unique position" the designated doctor's report occupies within the scheme of the 1989 Act, and the fact that such a report cannot be outweighed by a mere balancing of the evidence or even a preponderance of the evidence. Similarly, we have observed that no other doctor's report, including a report of a treating doctor, is accorded this special presumptive status. *See* Texas Workers' Compensation Commission Appeal No. 92366, decided September 10, 1992. Dr. W's report is entitled to presumptive weight and is in large part supported by Dr. O's evaluations and Dr. CZ's comments. The reports of Dr. CH do not constitute the great weight of other medical evidence necessary to overcome Dr. W's report. Accordingly, we find that the hearing officer did not err in his conclusion that the great weight of other medical evidence is not contrary to Dr. W's report that MMI was reached on September 28, 1992 and that claimant has a 12 percent whole body impairment.

Where, as here, there is sufficient evidence to support the hearing officer's determinations, there is no sound basis to disturb his decision. Only if we were to determine, which we do not in this case, that the determinations of the hearing officer were so against the great weight and preponderance of the evidence as to be manifestly wrong or unjust would we be warranted in setting aside his decision. In re King's Estate, 244 S.W.2d 660 (Tex. 1951); Texas Workers' Compensation Commission Appeal No. 92232, decided July 20, 1992. We do not so find.

The decision of the hearing officer is affirmed.

Thomas A. Knapp
Appeals Judge

CONCUR:

Stark O. Sanders, Jr.
Chief Appeals Judge

Joe Sebesta
Appeals Judge